LETTERS TO THE EDITOR

Regarding "Operative salvage of radiocephalic arteriovenous fistulas by formation of a proximal neoanastomosis"

We congratulate the authors on their 90% radial cephalic fistula rate and the good results obtained by surgical correction of malfunctioning arteriovenous fistulas using a proximal neoanastomosis.[1] However, we would like to make the following observations:

The authors do not indicate the site of stenosis that caused the fistula failure. In most patients with stenosis of the fistula, the lesion will be in the swing segment.[2] Even in those that are classed as an anastomotic stenosis (ie, at or ≤2 cm on either side of the anastomosis), more than half of the lesions will be on the venous side.[3]

In our experience, many of these patients will have an intact dorsal cephalic branch. By using this branch to perform a Yarl 2 vein flap fistuloplasty,[4] the stenosis can be corrected with excellent outcomes. Creating a neoanastomosis will create a new swing segment, with its attendant problems. Therefore, we respectfully submit that in carefully selected patients, vein flap fistuloplasty should be considered before a proximal neoanastomosis.

Anantha K. Ramanathan, MBBS

Department of Vascular Surgery
Central Coast Health
Gosford, New South Wales, Australia

Justin A. Roake, MBChB, DPhil

Department of Vascular Surgery
Christchurch Hospital
Christchurch, New Zealand

REFERENCES

1. Mallik M, Sivaprakasam R, Pettigrew GJ, Callaghan CJ. Operative salvage of radiocephalic arteriovenous fistulas by formation of a proximal neoanastomosis. J Vasc Surg 2011;54:168-73.
2. Badero OJ, Salifu MO, Wasse H, Work J. Frequency of swing-segment stenosis in referred dialysis patients with angiographically documented lesions. Am J Kidney Dis 2008;51:93-8.
3. Long B, Brichart N, Lermusiaux P, Turmel-Rodrigues L, Artru B, Boutin JM, et al. Management of perianastomotic stenosis of direct wrist autogenous radial-cephalic arteriovenous accesses for dialysis. J Vasc Surg 2011;53:108-14.
4. Ramanathan AK, Roake J. Yarl vein flap fistuloplasties for juxta-anastomotic stenoses. Ann R Coll Surg Engl 2011;93:170.

http://dx.doi.org/10.1016/j.jvs.2011.08.064

Reply

We thank Ramanathan and Roake for their interest in our recent article. We agree that many of the venous stenoses that led to proximal revision may well have been in the swing segment, although we were unable to record this in our article as this information was not recorded prospectively. Although the Yarl fistuloplasty may be of use in nonthrombosed fistulas where a nearby venous tributary is present, 25 of the 81 patients in our series had revision for thrombosis. In our experience, venous collaterals of a sufficient size near a perianastomotic stenosis are uncommon, further limiting the utility of this technique. Unfortunately, the article quoted by the correspondents does not describe complications or outcomes with the Yarl fistuloplasty.

Mekhola Mallik, MBBS, MRCS
Gavin Pettigrew, MD
Chris Callaghan, PhD, FRCS

Department of Surgery
Addenbrooke's Hospital
Cambridge, United Kingdom

doi:10.1016/j.jvs.2011.10.010

Regarding "An all-inclusive and transparent view of a vascular program's direct impact on its health system"

Taylor et al[1] present a useful review of a vascular surgery service line impact on hospital revenue. Such information is critical when approaching hospital administration for service-related capital requests, contracting discussions, and programmatic development. The reporting of financial data, however, is variable and represents a multitude of factors on both the revenue and cost sides.

Revenue is highly dependent on payer mix, insurance contracting, and regional differences in Medicare payment rates. As such, methodologic translation to other health systems may be difficult, particularly when exploring cost-to-revenue ratios and other service-related metrics. To account for these variations, the use of payer neutral revenue (PNR) has been suggested.[2]

Briefly, PNR methodology "corrects" for payer status and assumes that all revenue would be derived from published standard Medicare rates. Although this does not identify true revenue dollars per se, it is a powerful tool for identifying cost variations within and across health systems, managing practice variability, improving operation efficiency, and planning for potential future decreases in reimbursement. Armed with such data, service line best practices and improved efficiency can be presented to leadership immune to differences in payer status and mix. For example, although vascular surgery net revenue at a large suburban hospital may be high compared with a smaller inner-city institution due to payer mix, evaluation using a PNR method can highlight unrecognized fiscal efficiency with regard to cost, an important factor in hospital operations. I suggest that the *Journal of Vascular Surgery* and other peer-reviewed medical publications adopt standardized cost and revenue methodology to broaden translation across health systems.

Stephen Motew, MD

Salem Vascular Specialists
Novant Medical Group
Winston-Salem, NC

REFERENCES

1. Taylor N, Lombardi JV, Toddes S, Alexander J, Trani J, Carpenter J. An all-inclusive and transparent view of a vascular program's direct impact on its health system. J Vasc Surg 2012;55:281-5.
2. Weinstock M. A model of efficiency. Hosp Health Netw 2009;83:20-4, 1.

doi:10.1016/j.jvs.2012.02.043

Reply

The use of payer neutral revenue methodology levels the playing field when it comes to revenue, and when reporting across different health systems for comparison, it makes great sense. There are some issues on the cost side, however: All facilities have